SERFF Tracking Number:	*DDAR-127287314*	*State:*	*Arkansas*
Filing Company:	*Delta Dental of Arkansas*	*State Tracking Number:*	*49103*
Company Tracking Number:	*D-ENR-11*		
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*D-ENR-11*		
Project Name/Number:	*D-ENR-11/*		

Filing at a Glance

Company: Delta Dental of Arkansas

Product Name: D-ENR-11	SERFF Tr Num: DDAR-127287314	State: Arkansas
TOI: H10G Group Health - Dental	SERFF Status: Closed-Approved-Closed	State Tr Num: 49103
Sub-TOI: H10G.000 Health - Dental	Co Tr Num: D-ENR-11	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Author: Sara Farris	Disposition Date: 06/30/2011
	Date Submitted: 06/22/2011	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: D-ENR-11	Status of Filing in Domicile:
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments: I erred in my Filing Description: this enrollment form is for groups that have only purchased dental coverage (not vision).
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small and Large
Group Market Type: Association, Employer	Overall Rate Impact:
Filing Status Changed: 06/30/2011	
State Status Changed: 06/30/2011	Deemer Date:
Created By: Sara Farris	Submitted By: Sara Farris

Corresponding Filing Tracking Number:

Filing Description:

This is an enrollment form for groups that have only purchased vision.

Company and Contact

Filing Contact Information

Sara Farris,	sfarris@ddpar.com

SERFF Tracking Number:	*DDAR-127287314*	*State:*	*Arkansas*
Filing Company:	*Delta Dental of Arkansas*	*State Tracking Number:*	*49103*
Company Tracking Number:	*D-ENR-11*		
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*D-ENR-11*		
Project Name/Number:	*D-ENR-11/*		

1513 Country Club
Sherwood, AR 72120

501-992-1662 [Phone]
501-992-1663 [FAX]

Filing Company Information

Delta Dental of Arkansas	CoCode: 47155	State of Domicile: Arkansas
1513 Country Club Rd.	Group Code:	Company Type:
Sherwood, AR 72120	Group Name:	State ID Number:
(501) 992-1662 ext. [Phone]	FEIN Number: 71-0561140	

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Delta Dental of Arkansas	$50.00	06/22/2011	48986313

SERFF Tracking Number:	*DDAR-127287314*	*State:*	*Arkansas*
Filing Company:	*Delta Dental of Arkansas*	*State Tracking Number:*	*49103*
Company Tracking Number:	*D-ENR-11*		
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*D-ENR-11*		
Project Name/Number:	*D-ENR-11/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/30/2011	06/30/2011

SERFF Tracking Number:	*DDAR-127287314*	*State:*	*Arkansas*
Filing Company:	*Delta Dental of Arkansas*	*State Tracking Number:*	*49103*
Company Tracking Number:	*D-ENR-11*		
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*D-ENR-11*		
Project Name/Number:	*D-ENR-11/*		

Disposition

Disposition Date: 06/30/2011
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*DDAR-127287314*	*State:*	*Arkansas*
Filing Company:	*Delta Dental of Arkansas*	*State Tracking Number:*	*49103*
Company Tracking Number:	*D-ENR-11*		
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*D-ENR-11*		
Project Name/Number:	*D-ENR-11/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Form	D-ENR-11	Approved-Closed	Yes

SERFF Tracking Number:	*DDAR-127287314*	*State:*	*Arkansas*
Filing Company:	*Delta Dental of Arkansas*	*State Tracking Number:*	*49103*
Company Tracking Number:	*D-ENR-11*		
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*D-ENR-11*		
Project Name/Number:	*D-ENR-11/*		

Post Submission Update Request Processed On 06/22/2011

Status:	Allowed
Created By:	Sara Farris
Processed By:	Rosalind Minor
Comments:	

General Information:

Field Name	Requested Change	Prior Value
Domicile Status Comments	I erred in my Filing Description: this enrollment form is for groups that have only purchased dental coverage (not vision).	

SERFF Tracking Number:	*DDAR-127287314*	*State:*	*Arkansas*
Filing Company:	*Delta Dental of Arkansas*	*State Tracking Number:*	*49103*
Company Tracking Number:	*D-ENR-11*		
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*D-ENR-11*		
Project Name/Number:	*D-ENR-11/*		

Form Schedule

Lead Form Number: D-ENR-11

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 06/30/2011	D-ENR-11	Application/ Enrollment Form	D-ENR-11	Initial			D-ENR-11.pdf

DELTA DENTAL

DENTAL ENROLLMENT/CHANGE FORM

Delta Dental of Arkansas
P.O. Box 15965
Little Rock, AR 72231
E-mail: eligibility@ddpar.com

☐ New Enrollment ☐ Status Change ☐ Address Change
☐ Termination ☐ Cobra

Effective Date

Month	Day	Year

Group Number: _____

Group Name: _____

Social Security Number

Subscriber's Identifier (if applicable)

LAST NAME: _____ FIRST: _____ MI: ____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

EMAIL ADDRESS: _____

Date of Birth
/ /
MM DD YY

Marital Status
☐ Single
☐ Married

Sex
☐ Male
☐ Female

Date of Hire
/ /
MM DD YY

NOTE: Certain medical conditions may entitle you and/or your covered dependents to additional benefits. Please mark any conditions that apply to you (Under section 2 below, please enter Code for affected dependents in the box entitled "EBD Code."

Enter P for pregnant, D for diabetes, and H for Heart Disease)

☐ Pregnancy - Expected due date _____
☐ Diabetes - Date of onset _____
☐ Heart Disease - Date of onset _____

1. COVERAGE CHANGES

* Please check the box(es) next to the reason(s) for your change

Type coverage selected (choose one)

☐ Employee
☐ Employee/Spouse
☐ Employee/Child
☐ Employee/Children
☐ Employee/Family

☐ Add Dependent(s) **listed below**
☐ Remove Dependent(s) **listed below**
☐ Name Change
☐ Late Entrance (employee)

Reason(s) for Change:
☐ Marriage
☐ Divorce
☐ Birth or adoption of child
☐ Full Time Student
☐ Handicapped
☐ Other _____

☐ COBRA effective date _____

☐ Change Coverage
☐ Address Change only
☐ Qualifying event
☐ Late Entrance (dependent)

Date of event_____
☐ Loss of spouse's coverage
☐ No longer dependent child
☐ Death of dependent
☐ No longer Full Time Student

Other Coverage Info:
Do you have current dental coverage? ☐ Yes ☐ No
Is this coverage intended to replace your current dental coverage? ☐ Yes ☐ No

2. LIST ALL MEMBERS TO BE ENROLLED OR AFFECTED BY CHANGE

Add	Remove	EBD Code	Onset Date	**Last (if different)**	**First**	**MI**	**Relationship**	**Sex** M/F	**Birthdate** (MM/DD/YY)
☐	☐								
☐	☐								
☐	☐								
☐	☐								
☐	☐								
☐	☐								

3. AUTHORIZATION

I authorize dentists, dental office personnel, and other health care professionals and entities to disclose to Delta Dental of Arkansas, its agents and employees (including, without limitation, its claims and customer service personnel) all information necessary to determine (1) eligibility for coverage and (2) covered benefits. This authorization is made for each individual to be enrolled or affected by this change. The authorization is valid for 30 months from the date this form is signed for the purpose of collecting information in connection with enrollment, coverage reinstatement, or requests to change benefits. The authorization is valid for the term of coverage for the purpose of collecting information in connection with claims for benefits. The applicant or the applicant's authorized representative is entitled to receive a copy of the authorization form.

4. CERTIFICATION

I certify that the information supplied by me on this form is accurate to the best of my knowledge. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

☐ I have been offered the opportunity to enroll in the dental program through Delta Dental; however, **I waive coverage at this time**.
☐ I authorize payroll deductions.

Signature:_____ Date: _____

SERFF Tracking Number:	*DDAR-127287314*	*State:*	*Arkansas*
Filing Company:	*Delta Dental of Arkansas*	*State Tracking Number:*	*49103*
Company Tracking Number:	*D-ENR-11*		
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*D-ENR-11*		
Project Name/Number:	*D-ENR-11/*		

Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification	Approved-Closed	06/30/2011
Bypass Reason:	This is an enrollment form not subject to the Flesch Certification requirements.		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	06/30/2011
Bypass Reason:	This is an enrollment form not subject to this requirement.		
Comments:			